I am not sure what Dr. Hoffmann’s ultimate point is in “The Mental Status Exam: An Archaic Instrument” (Issues in Focus, December 2008, Vol. 7, No. 12, p. 26-28). Certainly there are limitations to a cursory “bedside” mental status exam (MSE). Equally certainly, there are diminishing returns when more and more time is devoted to the MSE, instead of to more formal, standardized testing instruments. And there is no question that an MSE should not be obtained in an informational vacuum; the results obtained must be assessed in the clinical context of the patient, including the psychosocial milieu (depression, psychosis) and the biochemical/metabolic status of the patient (renal or hepatic failure, for example.) This is basic medical school material.

But Dr. Hofmann seems to want to eliminate the mental status exam entirely. He seems to think that the information a neurologist is seeking from the MSE can be obtained more accurately by other means—by an MRI scan or a blood test. Is this what he is teaching neuro residents at Stanford? That we do an MSE to see if a patient is uremic? Or having a stroke? If this is what he truly believes, then I can only conclude that he doesn’t understand the purpose of the clinical exam itself in the practice of neurology.

It seems to me that neurologists assess patients because they are asked to do so by the patient him/herself, by the patient’s family, or by another physician, because the patient has some sort of symptom or problem that raises the suspicion that there is something wrong with the patient’s nervous system. These people don’t know much about the nervous system, so they seek the opinion and expertise of someone who does.

Often the presenting problem involves some sort of “alteration of mental status,” without further characterization. (Remember: the referring person doesn’t necessarily know enough to be more specific than that.) The neurologist, in assessing the patient, has to characterize that alteration of mental status with more precision before s/he can begin to formulate what is going on. The clinical neurologic exam, including a mental status exam, is a necessary means of getting the “lay of the land” on the patient before deciding what the problem actually is, what the potential causes are, and what tests (if any) should be done to make a diagnosis.

So, for example, a school-aged child is brought to me with the concern that there is something wrong with his “short-term memory,” based on performance at school and ability to perform household chores. I find him able to recall words, number sequences, and information like his address, friend’s names, etc. However, the history suggests significant inattention—a much more common problem in kids than dementia or Wernicke/Korsakoff syndrome or bilateral temporal lobe infarcts.

Or another example: A middle aged executive with chronic headaches, who insists that there are no problems in his performance at work and whose wife denies any mental status issue. The clinical exam, especially the mental status examination, is a necessary means of determining what is going on. Is it the complaints of the executive or his wife that are the correct ones? Only a full clinical exam can provide this information.
changes in personality. Basic exam is normal (motor, reflexes, fundi) but on MSE, he can’t do serial 7’s (inattentive) or recall more than one of three words at 5 minutes. Imaging shows “normal pressure” hydrocephalus—imaging that might not have been deemed necessary based on the symptoms or basic neuro exam.

Or the patient on the ward who is suddenly out of control: is he having a psychotic break, or is he a naturally aggressive criminal type who is demonstrating typical behavior, or is he in a state of delirium (defined as “agitated confusion”)? Don’t you have to sort this out before scanning him?

These are anecdotes, of course, and do not by themselves justify a practice that Dr. Hofmann characterizes as “game-playing.” But Dr. Hofmann offers no alternative suggestions as to how a neurologist should go about assessing a patient. If he were simply offering caveats about the limitations of the MSE (“Remember that, just because a patient can or can’t draw a clock, it doesn’t mean that . . .”), he could offer useful advice on how to use it. Instead, he simply tears it down. In fact, he tears down the entire neurologic assessment process! The “more objective measurements” obtained from testing reflexes and sensation are merely links to a descriptive or eponymous diagnosis that is “simply another word game of little help to the patient.”

Well! To me, this is equivalent to saying that neurologists are essentially obsolete. If the only useful information regarding neurologic disease can be obtained from a scan or a blood test, if there is no “value-added” from the history and exam that a neurologist performs, then a neurologist is not needed.

I don’t think that Dr. Hofmann really believes this, but this is the message that his article contains, in my opinion.

Maybe the useful details got edited out. It sounds like he is a retired practicing neurologist who is now teaching residents, and finding that what is being taught does not jibe with his experience. “[T]he problem in neurology remains that the instructions given with the hallowed halls may quickly have to be unlearned in the private office setting, where arrogance and nonsense are neither tolerated nor profitable.” Wow! Sounds to me like Dr. Hofmann knows a lot about how to efficiently and effectively assess neurologic patients that the academic types don’t. Sure would like to hear about that, but his only message is, “Don’t waste your time doing a mental status exam.”

Well, whatever Dr. Hofmann’s experience is in the hallowed halls of Stanford, I think that a good resident training program does encourage both “competence with today’s tools” and taking account of “the patient’s background, experience, and understanding.” And also teaches a resident how to do a mental status exam, how to devote an appropriate and not excessive amount of time on it based on the clinical context, and how to interpret the results appropriately.

I hope that Dr. Hofmann’s career in neurology has been more rewarding to him than his somewhat peevish rant suggests.

—Richard Jacobson MD PhD
Assoc. Professor of Neurology and Pediatrics, Medical College of Wisconsin

Reader Clarifies Issues of “Fraud”

The last sentence in the article “Upgrade your Practice for 2009” (December 2008, Vol. 7, No. 12, p. 37) is misleading. Guilt is determined by the judicial system, and the word “fraudulent” has a specific legal connotation.

I’d like to think that in the vast majority of cases, incorrect coding (up or down) is due to lack of understanding rather than fraudulent intent.

—Michael Gruenthal, MD, PhD
Professor and Bender Chair, Department of Neurology, Albany Medical Center

Editors’ Note: There was no intent to suggest that most neurologists would purposely submit inaccurate claims, and we regret any possible implication in that regard. Dr. Gruenthal makes an important point regarding the legalities of “guilt” and “fraud.” Note, however, that strictly speaking CMS and hence the Federal government considers any bill submitted improperly (whether due to accidental or purposeful billing) to be fraudulent. While prosecution for fraud due to occasional errors is unlikely, a physician who consistently under-codes is susceptible to a charge of fraudulent reporting—claims submitted are falsified in the sense that they do not accurately report the service provided.